High Tide Dentistry

Medical History Form

Thank you for choosing CDA! Please take a few minutes to fill out these forms to help us get to know you.

Patient's Name: _____ Date of Birth: ____ /____ /____ Today's Date: ____ /____ /____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills or drugs?	Yes	No	If yes
Did you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	If yes
Do you use tobacco?	Yes	No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Local Anesthetics
- Metal
- Latex
- Sulfa Drugs
- Other? If yes

Do you use controlled substances?

Yes No If yes

Please check any of the following conditions that apply to you:

- AIDS/HIV Positive
- Alzeimer's Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problems
- Bruise Easily
- Cancer
- Chemotherapy
- Chest Pain
- Cold Sores/Fever Blisters
- Congenital Heart Disorder
- Convulsions
- Cortisone Medication
- Diabetes
- Drug Addiction
- Easily Winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting Spells/Dizziness
- Frequent Cough
- Frequent Diarrhea
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart Attach/Failure
- Heart Murmur
- Heart Pacemaker
- Heart Trouble/Disease
- Hemophilia
- Hepatitis A
- Hepatitis B or C
- Herpes
- High Blood Pressure
- High Cholesterol
- Hives or Rash
- Hypoglocemia
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Mitral Valve Prolapse
- Osteoporosis
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Shingles
- Sickle Cell Disease
- Sinus Trouble
- Spina Bifida
- Stomach/Intestinal Disease
- Stroke
- Swelling of Limbs
- Thyroid Disease
- Tonsilitis
- Tuberculosis
- Tumors or Growths
- Ulcers
- Venereal Diseases
- Yellow Jaundice

Have you ever had any serious illness not listed? Yes No If yes

Comments:

Consent: *To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.*

Patient Signature *(parent if minor)* Date